Amendment No. 1 to SB2427

McNally
Signature of Sponsor

AMEND Senate Bill No. 2427 House Bill No. 2303*

by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following new part:

56-7-3401. This part shall be known and may be cited as the "Health Care Provider Stability Act."

56-7-3402. As used in this part, unless the context otherwise requires:

(1) "Health care provider" has the same meaning as in § 56-7-3301;

(2)

(A) "Material change" means a change in fees or payment methodologies that a reasonable person would attach importance to in determining the action to be taken upon the change;

(B) "Material change" includes:

(i) A change to fee schedules previously agreed upon by the third-party payer and a health care provider, the third-party payer's internal coding guidelines, edits, and payment rules, including but not limited to, multiple procedure payment reduction rules, claim payment procedures, or any other elements that the third-party payer utilizes to determine payment or reimbursement amounts; or

(ii) Any other means that a third-party payer or health care provider may utilize to adjust a rate for payment of items or

services previously agreed upon pursuant to a contract or fee schedule between the third-party payer and a health care provider; and

(C) "Material change" does not include:

(i) Any revision to the enrollee's benefit package;

(ii) Any process or program the third-party payer utilizes to determine the medical necessity of a health care item or service, including but not limited to, utilization review procedures and prior authorization determinations;

(iii) Any process or program a third-party payer utilizes to investigate and address fraud and abuse with regard to a health care provider it has contracted with to provide items or services to its beneficiaries;

(iv) A change in Current Procedural Terminology (CPT) codes pursuant to the release of CPT coding guidelines from the American Medical Association and the Centers for Medicare and Medicaid Services, as applicable;

(v) A change in internal coding guidelines pursuant to a development in evidence-based medicine guidelines issued by a source other than the third-party payer or health care provider that does not adjust the rate of payment previously agreed upon by the third-party payer and a health care provider in a contract;

(vi) Any change in the average wholesale price for immunizations, vaccines, injectables, and other drugs or solutions; or

(vii) Any change or addition in items or services to be provided by the health care provider and paid for by the third-party payer that does not adjust the rate of payment for items or services previously agreed upon by the third-party payer and health care provider; and

(3) "Third-party payer" means a health insurer, third-party administrator, or other person that is obligated pursuant to health insurance coverage or a health benefits plan to pay for covered health care services rendered to beneficiaries.

56-7-3403.

(a) If a third-party payer or health care provider desires to effect any material changes that adjust a previously agreed upon rate of payment for which a health care provider is paid for providing items or services, the third-party payer or health care provider must effect all material changes at one (1) time during a calendar year and is prohibited from effecting a subsequent material change for at least twelve (12) months from a material change.

(b) The third-party payer or health care provider is required to send written notice of a material change to the other party sixty (60) days prior to the effective date of the material change.

56-7-3404. A third-party payer or health care provider may maintain an individual or class action to enforce this part. The court may also award attorneys' fees and costs to the prevailing party. Venue for such actions shall be in the county in which the complaining party's principal place of business is located in the state of Tennessee.

56-7-3405. None of the requirements of this part may be waived by contract, and

any such purported waiver is void.

56-7-3406. Nothing in this part obviates a third-party payer's obligation to comply with any and all legal requirements to which such payer must comply with respect to participating or non-participating health care providers.

56-7-3407. Nothing in this part shall apply to any contract between a third-party payer and health care provider for items or services to be provided for individuals covered by the federal Medicare program, including Medicare Advantage, Medicare Select, Medicare Supplement, Medicare and Medicaid Enrollees (MME), Medicare Dual Special Needs, and Medicare Private Fee for Service; state, local government, or local education insurance plans established under title 8, chapter 27; the TennCare or Medicaid waiver program established under title 71, chapter 5; or any other health plan managed by the health care finance and administration division of the department of finance and administration.

56-7-3408. Nothing contained in this part shall be construed or interpreted as prohibiting either the third-party payer or the health care provider from terminating a contract for the provision and payment of health care items or services in accordance with mutually agreed upon terms in that contract.

SECTION 2. If any provision of this act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this act, and to this end the provisions of this act are hereby declared severable.

SECTION 3. This act shall take effect upon becoming a law, the public welfare requiring it, and shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the state on or after October 1, 2014.